MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-B Be 04893

CERTIFICATE OF DEATH

Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3113 East Preston Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lawrence Paul Beere

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1915

8. AGE:

Years	Months	Days	If less than one day
32			hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER

12. Name: Martin Beere

13. Birthplace: Germany

MOTHER

14. Maiden name: Mary E. Weber

15. Birthplace: Maryland

16. Informant: Hospital Records

Address:

(Burial, cremation, or removal. Which?) Burial Date thereof: June 30 47 (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: Baltimore Md.

18. Funeral director: John A. Moran

Address: 3000 E. Balto. St.

19. June 28 1947 (Date rec'd by registrar) C. Harvey Ebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 19 47 at 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 22 19 47 to June 27 19 47 and that I last saw him alive on June 27 19 47

	DURATION
Immediate cause of death	
Pulmonary Tuberculosis	unknown
Due to	
Due to	
Other conditions: Chronic Alcoholism (Include pregnancy within 3 months of death)	veteran

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Springfield State Hosp. Sykesville Md. Date signed: 6-27-47

Be sure all important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04894

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 7

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Clara Smith Billingslea

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

B.(b) Name of husband or wife: Charles Billingslea

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 20, 1856

8. AGE: Years	Months	Days	If less than one day
91	3	29	hrs. min.

9. Birthplace: Wakefield, Md.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John Smith

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Caroline Cookson

MOTHER — 15. Birthplace: Maryland

16. Informant: Susan H. Billingslea

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 6/21/47 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 6/20 19 47 (Date rec'd by registrar) L. C. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1947, at 5½ p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9th 1947, to June 18 1947

and that I last saw h... alive on June 18 1947

Immediate cause of death	DURATION
Cardiac Dilatation	15 Mins.
Due to: Chronic Myocarditis and Arterio Sclerosis	1 year
Due to:	
Other conditions: Coronary Disease.	2 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. C. Woodward M. D. or other

Address: Westminster Date signed: 6/20/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04895

462

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Alice Buffington

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	widow

6.(b) Name of husband or wife: James Buffington

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1862

8. AGE: Years	Months	Days	If less than one day
84	6	11	hrs. min.

9. Birthplace: Pa
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Henry K. Sherman

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Lizzie A. McConnell

MOTHER — 15. Birthplace: Pa.

16. Informant: Miss Ida Sherman

Address: York, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7, 1947 (month) (day) (year)

Cemetery or crematory: Lutheran

Location: Taneytown, Md.

18. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

19. June 7. 1947 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4th. 1947, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1st. 1947, to June 4th 1947 and that I last saw her alive on June 4th 1947

Immediate cause of death: Carcinoma of Sigmoid Flexure of Colon — DURATION: 6 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. M. Benner. M.D.
M. D. or other

Address: Taneytown, Maryland Date signed June 6th 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04896

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1428 Mosher St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: DOREATHA CANDY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Walter Candy
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): March 11, 1917

8. AGE: Years	Months	Days	If less than one day
30	2	26	...hrs. ...min.

9. Birthplace: Nashville, N. C. (Town, county, and state)
10. Usual occupation: Laundry Worker
11. Industry or business:

FATHER
12. Name: Leroy Boddie
13. Birthplace: Unknown

MOTHER
14. Maiden name: Emma L. Manning
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Shipped Date thereof 6/12/47 (month) (day) (year)
Cemetery or crematory:
Location: Rocky Mount, N. C.
18. Funeral director: Mrs Katie R. Sullivan
Address: 322 N. Schroeder St.

19. 6/6 (Date rec'd by registrar) 19 47 Albert R. Saunders Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6, 19 47, at 10.00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26, 19 47, to June 6, 19 47 and that I last saw her alive on June 6, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben O'Kuan, M. D. M. D. or other
Address: Henryton, Md. Date signed: 6/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04897

CERTIFICATE OF DEATH

Reg. Diat. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Arthur G. Clay

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Daisy Clay

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 1 1880

8. AGE: Years: 67 | Months: 5 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Harry Clay

13. Birthplace: Ohio

MOTHER — 14. Maiden name: Clara Hansford

15. Birthplace: Pennsylvania

16. Informant: Mrs. Clara Rogers

Address: 1711 McCullough St. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-20-47 (month) (day) (year)

Cemetery or crematory: National

Location: Baltimore Pennsylvania

18. Funeral director: C. M. Walsh

Address: Westfield Md

19. 6/19/47 (Date rec'd by registrar) Thos. W. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1947 at 7:38 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1947 to June 17 1947 and that I last saw h[illegible] alive on June 17 1947

Immediate cause of death: Coronary Occlusion — DURATION: Sudden

Due to: Hypertension and

Due to: Chron. Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. M. Van Pelt M. D. or other

Address: Mt Airy Md Date signed 6/18/47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

04898

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 9 months.
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 16 Pine Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN CONRAD COLLINS

3.(b) Social Security Number: 217-10-8519

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Lottie Collins
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): February 4, 1903

8. AGE: Years	Months	Days	If less than one day
44	4	0	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business:

FATHER
12. Name: Robert Collins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Amanda Bedford
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Lottie Collins
Address: Cambridge, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7-1947 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location: Baltimore Co. Md.
18. Funeral director: Geo. Conrad H. Holland
Address: 1631 Druid Hill Ave.
19. June 4, 1947 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4, 1947, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4, 1945, to June 4, 1947 and that I last saw him alive on June 4, 1947

Immediate cause of death	DURATION
Septicemia following extraction of teeth.	1 week
Due to:	
Due to:	
Other conditions: Pulmonary tuberculosis	Aug. 1945

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Kwan, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 6-4-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04899

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D 2, box 550

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ALMA COLLESTIA COOK

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 20, 1931

8. AGE:

Years	Months	Days	If less than one day
16	0	24	..... hrs. ..... min.

9. Birthplace: Anne Arundel Co., Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Sylverster Cook
13. Birthplace: Anne Arundel County, Md.

MOTHER
14. Maiden name: Frances Smith
15. Birthplace: Anne Arundel Counry, Md

16. Informant: Frences Smith

Address: R.F.D. 2, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17-47 (month) (day) (year)

Cemetery or crematory: Broadneck Cemetery

Location: [illegible] Annapolis Md.

18. Funeral director: [illegible]

Address: Annapolis, Md.

19. 6/13 19 47 [illegible] Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13, 19 47 at 7.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 19 47 to June 13, 19 47 and that I last saw her alive on June 13, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reuben W. Swan, M. D.
M. D. or other

Address: Henryton, Md Date signed 6/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

04900

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 72

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster, R.D. 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: (Myers District)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster, R.D. 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Myers District
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Jane Crouse

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John T. Crouse
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): June-19-1857

8. AGE: Years: 90 Months: 0 Days: 4 If less than one day: hrs. min.

9. Birthplace: Carroll Co. Md. (Town, county, and state)
10. Usual occupation: Retired Housework
11. Industry or business: Retired Housework

FATHER
12. Name: Richard Singling
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Henerietta Otter
15. Birthplace: Carroll Co. Md.

16. Informant: Mrs Elizabeth Brock
Address: Westminster, Md. R.D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June-26-1947 (month) (day) (year)
Cemetery or crematory: St Marys Union Cemetery
Location: Silver Run, Md.

18. Funeral director: J. W. Little & Son
Address: Littlestown, Pa. R.F.D. 4, Little

19. June 24- 1947 (Date rec'd by registrar) Calvin E. Barnett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June- 23 19 47, at 8:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 19 47, to June 23 19 47
and that I last saw her alive on June 23 19 47

Immediate cause of death	Acute Indigestion	DURATION
Underlying cause:	Organic Heart	
	[illegible]	
Due to		
Due to	Senile Degeneration	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John L. Stewart M. D. or other
Address: Westminster Md. Date signed: June 24 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

138 BC 04901

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 25 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 539 Mission Court
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
ESTHER MAE DAVIS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife Joseph Davis
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Feb., 24, 1915

8. AGE:

Years	Months	Days	If less than one day
32	4	6	hrs. min.

9. Birthplace Rock Hill, S. C.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name George Henderson
13. Birthplace South Carolina

MOTHER
14. Maiden name Leila Huggins
15. Birthplace South Carolina

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7-47 (month) (day) (year)
Cemetery or crematory Mt Auburn
Location Baltimore City
18. Funeral director Geo. G. Kelson
Address 1803 Presstman St

19. 6/30 (Date rec'd by registrar) 19 47 Albert R Grantham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1947, at 9.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1947, to June 30, 1947 and that I last saw her alive on June 30, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Jan. 25 1947
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W Brown, M.D.
M. D. or other
Address Henryton, Md. Date signed 6/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 042 942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Lyksville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Lyksville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Cordelia E. Dixon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife Thomas M. Dixon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1881

8. AGE: Years	Months	Days	If less than one day
65	9	7	..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name John Barth

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Mary M. Wolbert

MOTHER 15. Birthplace Md.

16. Informant Mr. Thomas M. Dixon

Address Lyksville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 11, 1947 (month) (day) (year)

Cemetery or crematory Morgan Chapel Cemetery

Location Mt. Woodbine, Carroll Co., Md.

18. Funeral director C. Harry Weer

Address Lyksville, Md.

19. June 10 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947, at 4-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to June 8 1947

and that I last saw alive on June 8 1947

Immediate cause of death Cardio Vascular disease — DURATION

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE N. A. Barnes MD M. D. or other

Address Lyksville Md Date signed 6/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04903

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 yrs., 3 mos., 3 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 41 yrs., 3 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. Unk
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WALTER ELLINGER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months ? | Days ? | If less than one day ... hrs. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation clerk

11. Industry or business

FATHER 12. Name Isaac Ellinger

13. Birthplace Maryland

MOTHER 14. Maiden name Isabella Pollard

15. Birthplace Maryland

16. Informant Springfield State Hosp. records

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-20-47 (month) (day) (year)

Cemetery or crematory New Cathedral, Balto.

Location Balto. Md.

18. Funeral director Henry C. Casty, Co.

Address Frederick, Md.

19. June 19 1947 (Date rec'd by registrar) C. Henry Elseo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to June 19 1947 and that I last saw him alive on June 18, 1947

Immediate cause of death	DURATION
chronic myocarditis and myocardial degeneration	9 yrs.
Due to arteriosclerosis and hypertension	
Due to	
Other conditions schizophrenia, hebephrenic type	45 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Bertrand May, M.D.
M. D. or other

Address Sykesville, Md. Date signed 6-19-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04904

50

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4½ years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 23 Carroll St.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Ruth Matilda Falkenstein

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Elwood S. Falkenstein

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): January 13, 1897

8. AGE:	Years	Months	Days	If less than one day
	50	4	24	...hrs. ...min.

9. Birthplace: York, Penna.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Alexander Diehl

13. Birthplace: Penna.

MOTHER 14. Maiden name: Emma Beck

15. Birthplace: Penna.

18. Informant: Rev. Elwood S. Falkenstein

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 6/9/47 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: York, Penna.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 6/7 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 19 47, at 6¾ a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 19 47, to June 6 19 47

and that I last saw her alive on June 6 19 47

Immediate cause of death	DURATION
Cancer of breast Lymph extending into lungs	7 mos
Due to	
Due to	
Other conditions Metastatic Growths ? in bones & liver etc.	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ...Injured at work?

23. SIGNATURE: J. Reese Falkenstein M.D.
M. D. or other

Address: Westminster Date signed: 6/7/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04905

61

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs. 7 mos. 8 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 9 yrs. 7 mos. 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1509 Lancaster Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MARJANNA FARYSIAK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1885

8. AGE: Years	Months	Days	If less than one day
62(?)			hrs. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal: Which?) Date thereof: June 13, 1947 (month) (day) (year)

Cemetery or crematory: Holy Cross Cem.

Location: Balto. Md.

18. Funeral director: Leonard J. Ruck

Address: 5305 Harford Rd.

19. June 13 1947 (Date rec'd by registrar) C. Harry Weer. Registrar

MEDICAL CERTIFICATION DST

20. DATE OF DEATH: 6/12 19 47, at 7:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/7 19 47, to 6/12 19 47

and that I last saw her alive on 6/12 19 47

Immediate cause of death	DURATION
Opticemia, Purulent	2 days.
Due to: Infection of foot.	1 week
Due to: Diabetes	unknown
Other conditions: Dementia,	?
Psychosis with convulsive disorder, epilepsy	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 6/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04906

CERTIFICATE OF DEATH

Reg. Diat. No. 75

1. PLACE OF DEATH:
County Carroll
City or town Lineboro Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Lineboro Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Warner Fields

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W.

6.(b) Name of ~~husband~~ or wife Anna M Ellis
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 19 - 1876

8. AGE: Years	Months	Days	If less than one day
71	4	22	..... hrs. ..... min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name John B Fields
13. Birthplace Virginia
MOTHER 14. Maiden name Elizabeth Holdenfield
15. Birthplace Virginia
16. Informant Mrs M. E. Birkhead
Address Lineboro Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14/47 (month) (day) (year)
Cemetery or crematory Church of God cemetery
Location Hampstead Md
18. Funeral director Edw C Tipton
Address Hampstead Md.
19. June 12th 1947 (Date rec'd by registrar) Wm. M. R. S. Deaner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at 11:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Marsh Deputy Medical Examiner
M. D. or other
Address Westminster Md Date signed 6-11-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

938 04907 BC

Reg. Dist. No. 24

P

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo 29 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 2 mo 29 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 351 S Fulton Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Minnie Estelle Flinn

3.(b) Social Security Number:

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: William Bernard Flinn

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 13 1874

8. AGE: Years: 72 Months: 10 Days: 17 If less than one day: hrs. min.

9. Birthplace: Carroll Co (Town, county, and state)

10. Usual occupation: Practical Nurse

11. Industry or business:

FATHER — 12. Name: Nathan Stephens

13. Birthplace: Md

MOTHER — 14. Maiden name: Elizabeth Eleanora Flinn

15. Birthplace: Md

16. Informant: Mrs Edith M Flinn

Address: 351 S Fulton Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/3/47 (month) (day) (year)

Cemetery or crematory: Par kwood Cem.

Location: Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md

19. 7/2 1947 (Date rec'd by registrar) A. W. Hedrick DMS Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30th 1947 at 11:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2d 1947, to June 30 1947 and that I last saw h[illegible] alive on June 30 1947

Immediate cause of death: Chronic Hypernutrition — DURATION: 10 yrs

Due to: Arterio Sclerosis — 4 yrs

Due to: Hypertension — 8

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. H. Haslup M.D. M. D. or other

Address: Sykesville Md Date signed 7/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

04908

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Carroll
County
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yr., 1 mo., 29 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 yr., 1 mo., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 195 Welsh Hill
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry Freel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: York-
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 15, 1871

8. AGE: Years	Months	Days	If less than one day
75	5	18	..... hrs. ..... min.

9. Birthplace: Frostburg, Maryland
(Town, county, and state)
10. Usual occupation: miner
11. Industry or business: coal

FATHER
12. Name: Hugh Freel
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Gallagher
15. Birthplace: Ireland

16. Informant: Springfield State Hospital records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-6-47 (month) (day) (year)
Cemetery or crematory: Frostburg
Location: Frostburg, Md.
18. Funeral director: J. J. Durst
Address: Frostburg, Md.

19. June 4 1947 (Date rec'd by registrar) C. Harry Freed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 19 47 at 9:35P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43, to June 3 19 47
and that I last saw him alive on June 3 19 47

Immediate cause of death	DURATION
Cerebral hemorrhage	3½ hrs.
Due to: Arteriosclerosis & hypertension	
Due to:	
Other conditions: Senile Psychosis	8 years

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
M. D. or other
Address: Springfield State Hospital
Sykesville, Maryland
Date signed: 6-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04909

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Federalsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Preston Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: FRANCIS ROMAIN FRIEND

3.(b) Social Security Number: 138-03-0877

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 9, 1912

8. AGE: Years	Months	Days	If less than one day
35	4	17	hrs. min.

9. Birthplace: Federalsburg, Md. (Town, county, and state)

10. Usual occupation: Shipyard Worker

11. Industry or business

FATHER — 12. Name: Robert Romain Friend

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Alice Smith

MOTHER — 15. Birthplace: Maryland

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 30 47 (month) (day) (year)

Cemetery or crematory: Federalsburg.

Location: Federalsburg maryland

18. Funeral director: J.J. Frampton Son.

Address: Federalsburg maryland.

19. 6/26 (Date rec'd by registrar) 19 47 Albert R. Trumbauer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26, 19 47 at 6.00A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9, 19 47, to June 26, 19 47 and that I last saw him alive on June 26, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben A. Kwan, M.D. M. D. or other

Address: Henryton, Md. Date signed: 6/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

04910

CERTIFICATE OF DEATH

Reg. Dist. No. 15

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Harry Irvin Gemmill

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife: Carrie Gemmill
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 9 - 1871

8. AGE: Years: 75 | Months: 6 | Days: 6 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll Co. Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: —

FATHER
12. Name: John Gemmill
13. Birthplace: Md

MOTHER
14. Maiden name: Emily Sullivan
15. Birthplace: Md -

16. Informant: Mrs. Ethel Sterner
Address: Manchester

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6.18.47 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: St. David Yorks Co. Pa.

18. Funeral director: Jacob U. Winkelbleck Sons
Address: Manchester Md.

19. June 16th 1947 Mrs W. P. S. Demmler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1947, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gunshot wound of head	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 6-17-47
Where did injury occur? Manchester (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Shot gun wound Injured at work? No

23. SIGNATURE: Thos. L. Thoral Deputy Medical Examiner
M. D. or other
Address: Westminster Md Date signed 6/15/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04911

CERTIFICATE OF DEATH

Reg. Dist. No. 73

1. PLACE OF DEATH:
County Carroll
City or town Manchester (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Emma Gertrude Gonder

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: William Gonder
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 2 - 1862

8. AGE: Years 85 | Months - | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Nurse

11. Industry or business

FATHER
12. Name John Lynerd
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Frank Forles
15. Birthplace Maryland

16. Informant Miss Nellie Lynerd
Address Manchester, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3 47 (month) (day) (year)
Cemetery or crematory W.M.B. Cemetery
Location Manchester, Md
18. Funeral director Edw. C. Tipton
Address Hampstead, Md.

19. June 30 1947 Mrs. W. R. S Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947 at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1947 to June 29 1947 and that I last saw her alive on June 29 1947

Immediate cause of death	DURATION
(a) Chronic Myocarditis.	7
Due to (b) Generalized Arteriosclerosis	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE Geo. E. Buck M.D.
M. D. or other
Address Hampstead Md. Date signed 6-30-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04912

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yr's, 8 Mo's, 29 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 149 W. All Saints Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ARTHUR HOWARD GRAY

3.(b) Social Security Number: 214-14-6595

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 17, 1923

8. AGE:

Years	Months	Days	If less than one day
24	3	1	hrs. min.

9. Birthplace: Frederick, Md. (Town, county, and state)

10. Usual occupation: Delivery Boy

11. Industry or business:

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Jeannette Sutton

15. Birthplace: Frederick, Md.

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-21-47 (month) (day) (year)

Cemetery or crematory: Fairview Cemetery

Location: Frederick, Md.

18. Funeral director: M. R. Etchison & Son

Address: Frederick, Md.

19. 6/18 (Date rec'd by registrar) 19 47 Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18, 19 47, at 6.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20, 19 42, to June 18, 19 47 and that I last saw him alive on June 18, 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to:	
Due to:	
Other conditions: Pulmonary Tuberculosis	Aug. 1942

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D. M. D. or other

Address: Henryton, Md Date signed: 6/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04913

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1421 Lafayette Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elmore Green

3.(b) Social Security Number: 220-03-1117

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Mable Green
6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): October 1, 1921

8. AGE: Years	Months	Days	If less than one day
25	8	7	hrs. min.

9. Birthplace: Franklinton, N. C.
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER 12. Name: Johnnie T. Green
13. Birthplace: Franklinton, N. C.

MOTHER 14. Maiden name: Hattie B. Burrell
15. Birthplace: Franklinton, N. C.

18. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-11-47 (month) (day) (year)
Cemetery or crematory: Franklinton
Location: N. C.
18. Funeral director: Geo. G. Kelson
Address: 313 Restman St.

19. 6/8 19 47 (Date rec'd by registrar) Albert R. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 19 47, at 1.15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4, 19 47, to June 8 19 47 and that I last saw him alive on June 8, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Swan, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 6/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04914

BC

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 2 mo's., 2 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 823 W. Lexington St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN HARRISON HOLLEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 10, 1919

8. AGE: Years	Months	Days	If less than one day
27	9	29	hrs. min.

9. Birthplace: Eden, N. C.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Abe Holley
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rose Holley
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 6/11/47 (month) (day) (year)
Cemetery or crematory: Shipped
Location: Edenton N.C. Carolina
18. Funeral director: Katie R. Milligan
Address 322 N. Schroeder St

19. 6/8 (Date rec'd by registrar) 19 47 Albert R. Swankhan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8 19 47 at 8.20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6, 19 47, to June 8, 19 47
and that I last saw him alive on June 8, 19 47

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1946
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md Date signed: 6/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830 04915

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George W. Holliday

3.(b) Social Security Number: 215-20-9315

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Widowed

6.(b) Name of husband or wife: Late
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 25-1869

8. AGE: Years: 77 | Months: 5 | Days: 28 | If less than one day: hrs. ..... min.

9. Birthplace: Carroll County Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: By Day

FATHER
12. Name: not known
13. Birthplace: Known

MOTHER
14. Maiden name: not known
15. Birthplace

16. Informant: Charles Roberts
Address: Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 25-47 (month) (day) (year)
Cemetery or crematory: Mt. Joy Cemetery
Location: Uniontown, Md.

18. Funeral director: D. H. Shriver & Sons
Address: Union Bridge & New Windsor, Md.

19. June 24 1947 (Date rec'd by registrar) L. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 1947, at 6:45 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 20 1947, to June 22 1947
and that I last saw h.. alive on June 21 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to:	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. A. Legg M. D., or other
Address: Union Bridge Date signed: 6-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04916

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years, 2 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 5 years, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: City
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5506 Morello Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mildred K. Kummer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10/3/20

8. AGE: Years	Months	Days	If less than one day
26	8	6	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: Charles A. Kummer
FATHER 13. Birthplace: Baltimore, Maryland
MOTHER 14. Maiden name: Nettie Bickel
MOTHER 15. Birthplace: Baltimore, Maryland
16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-12-47 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto. Md.
18. Funeral director: Leonard J. Rusk
Address: 3305 Harford Rd.
19. June 10 1947 (Date rec'd by registrar) C. Harry Eckert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/9 1947, at 8:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/27 1947, to 6/9 1947
and that I last saw h... ar... alive on 6/9/ 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11/46
Due to:	
Due to:	
Other conditions: Schizophrenia, Simple type (Include pregnancy within 3 months of death)	8 years

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M.D. or other
Address: Sykesville, Maryland Date signed: 6/9/47

VS A-15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04917

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 7mos., 5 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1030 S. Sharp St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME DIX LEMON

3.(b) Social Security Number 216-03-9290

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Susan Lemon
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): April 10, 1897

8. AGE: Years	Months	Days	If less than one day
50	2	20	....hrs. ....min.

9. Birthplace: Manning, S.C.
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business

FATHER
12. Name: Annison Lemon
13. Birthplace: Manning, S.C.

MOTHER
14. Maiden name: Atlee David
15. Birthplace: Manning, S.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/3/47 (month) (day) (year)
Cemetery or crematory: Manning
Location: S C

18. Funeral director: J. J. Brown & Son
Address: 108 W Montgomery St

19. June 30, 1947 (Date rec'd by registrar) Albert R. Swanbaum Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30, 1947, at 7:20 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 11, 1944, to June 30, 1947
and that I last saw him alive on June 30, 1947

Immediate cause of death	DURATION
Pulmonary tuberculosis	May 44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 6/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04918

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Dr. William Frank Lucas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Harriet Elizabeth Thomas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 30, 1866

8. AGE: Years	Months	Days	If less than one day
81	2	0	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Medical Doctor

11. Industry or business

FATHER — 12. Name Samuel Lucas Hatter

FATHER — 13. Birthplace Md.

MOTHER — 14. Maiden name Mary Burke

MOTHER — 15. Birthplace Md.

16. Informant Mr. William F. Lucas

Address 4720 Park Heights Ave.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof July 2, 1947 (month) (day) (year)

Cemetery or crematory London Park

Location Balto. Md.

18. Funeral director John F. Denny, Inc.

Address Light & Montgomery Sts.

19. June 30 1947 (Date rec'd by registrar) C. Harry Zibell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1947 19.., to death 6/30 1947 and that I last saw h.i.m. alive on June 30, 1947 19..

Immediate cause of death	DURATION
Chr. myocarditis	
auricular fibrillation cardiovascular disease	
Due to	
senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm. F. Lucas M.D. M. D. or other

Address Sykesville, Md. Date signed 6/30/47

M

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VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 04919

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Rural near Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 8 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 11 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Garrett
City or town Oakland (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME BOYD FRANCIS MARTIN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
73			hrs. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual occupation laborer
11. Industry or business lumber yards
FATHER 12. Name Peter Martin
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Bell Mason
15. Birthplace
16. Informant Springfield State Hosp. records
Address Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-14-47 (month) (day) (year)
Cemetery or crematory Redhouse
Location Garrett Co., Md.
18. Funeral director Herbert C. Leighton
Address Oakland, Md.
19. June 12 1947 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 19 47, at 9:00 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3 1946 to June 11 1947 and that I last saw him alive on June 11 1947

Immediate cause of death	DURATION
Arteriosclerosis	Prior to 1946
Due to	
Due to	
Other conditions Psychosis with cerebral arteriosclerosis (Include pregnancy within 3 months of death)	1 yr.

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert Bertrand May, M.D. M. D. or other
Address Sykesville, Maryland Date signed 6-12-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

049211

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 yrs., 11 m., 29 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 31 yrs., 11 m., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unk -
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

FRED MATTHAI

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13, 1869

8. AGE: Years	Months	Days	If less than one day
77	11	3	hrs. min.

9. Birthplace: Howard County, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Christian E. Matthai
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Spielhaus
15. Birthplace: Germany

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-18-47 (month) (day) (year)

Cemetery or crematory: Baltimore Cem.

Location: Baltimore Md

18. Funeral director: Leonard Roche

Address: 5305 Harford Rd

19. June 16 1947 (Date rec'd by registrar) C. Henry Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16, 1947 at 12:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to June 16 1947 and that I last saw him alive on June 16 1947

Immediate cause of death	DURATION
Arteriosclerosis	Prior to 1942
Due to:	
Due to:	
Other conditions: Psychosis with mental deficiency (Include pregnancy within 3 months of death)	34 yrs.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 6-16-47

M

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VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

BC 04921

CERTIFICATE OF DEATH

Reg. Dist. No. 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years, 2 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 12 years, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3610 OLD FREDERICK ROAD
(If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3.(a) FULL NAME: Daniel Edward McEntee

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 9, 1887

8. AGE: Years	Months	Days	If less than one day
59	8	27	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: grinder

11. Industry or business: spectacle lenses

FATHER — 12. Name: James McEntee

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Eliza Dunn

15. Birthplace: Baltimore, Maryland

16. Informant: Springfield State Hospital records

Address: Sykesville, Maryland

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: JUNE 9-1947 (month) (day) (year)

Cemetery or crematory: NEW CATTLE DRAL

Location: BALTIMORE MD

18. Funeral director: Roff & B. M. Walker

Address: Pratt & Strieker Sts

19. 6/6/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6, 1947, at 12:33a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943, to June 6, 1947, and that I last saw him alive on June 5, 1947.

Immediate cause of death: Acute cardiac decompensation — DURATION: 6 days

Due to: Arteriosclerosis

Due to:

Other conditions: Schizophrenia, paranoid type — 16 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

Springfield State Hospital
Address: Sykesville, Maryland Date signed: 6-6-47

05460

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 14 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Rock Point (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: PARIS RICHARD MIDDLETON

3.(b) Social Security Number: 220-09-2919

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 27, 1917

8. AGE: Years	Months	Days	If less than one day
30	2	24	..... hrs. ..... min.

9. Birthplace: Thomkinsville, Md. (Town, county, and state)

10. Usual occupation: Oystering & Fishing

11. Industry or business

FATHER — 12. Name: Charles H. Middleton

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Sarah Thomas

MOTHER — 15. Birthplace: Unknown

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/23/47 (month) (day) (year)

Cemetery or crematory: Holy Ghost

Location: Issue, Md.

18. Funeral director: Hurtt & Ryon

Address: Waldorf, Md.

19. 6/20 (Date rec'd by registrar) 19 47 Albert R. Chamberlain Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20, 19 47, at 10.55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 19 47, to June 20, 19 47 and that I last saw h im alive on June 20, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed 6/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04922

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs. 6 mos. 4 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 19 yrs. 6 mos. 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 517 East 35th Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Fannie R. Moller

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March, 1895 (day unknown)

8. AGE: Years	Months	Days	If less than one day
52	? 3	?	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business:

FATHER

12. Name: Frederick Moller

13. Birthplace: Baltimore, Maryland

MOTHER

14. Maiden name: Julia Andrathy

15. Birthplace: Baltimore, Maryland

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-17-47 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Ulee

Address: Sykesville, Md.

19. June 17 1947 (Date rec'd by registrar) C. Harry Ulee Registrar

MEDICAL CERTIFICATION

(DST)

20. DATE OF DEATH: 6/12 19 47 at 12:20 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/41 19 , to 6/12 19 47 and that I last saw her alive on 6/12 19 47

Immediate cause of death	DURATION
Pulmonary tuberculosis	Since 4/37
Due to:	
Due to:	
Other conditions: Schizophrenia, Catatonic type (Include pregnancy within 3 months of death)	since 1912

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 6/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

04923

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 86 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. New Windsor Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Albin D. Myers

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Catharine J. Starner
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
about 86			hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Farmer Ret.

11. Industry or business

FATHER
12. Name Daniel Myers
13. Birthplace Gettysburg, Pa.

MOTHER
14. Maiden name not known
15. Birthplace " "

16. Informant Charles F. Myers
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7 - 1947 (month) (day) (year)
Cemetery or crematory Bridge Cemetery
Location Westminster, Md.

18. Funeral director H. Bankard & Son
Address Westminster, Md.

19. 6/6 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1947, at 2.0 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1947, to June 4 1947
and that I last saw h alive on June 3 1947

Immediate cause of death	DURATION
Coronary Occlusion	1 hour
Due to Chronic myocarditis	4 yrs
Due to Arterio-sclerosis	8 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lelan R Fout M.D.
M. D. or other
Address Westminster Md. Date signed 6-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B 04924

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 1 day

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1135 N. Stricker St., (If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: VERNON NEEDUM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 31, 1909

8. AGE: Years: 38 Months: 0 Days: 7 If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Car Runner

11. Industry or business:

FATHER — 12. Name: Samuel Needum

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Maggie Fittchet

MOTHER — 15. Birthplace: Virginia

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/11/47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location:

18. Funeral director: Mrs Katie L Williams

Address: 322 N. Schroeder st

19. 6/7 (Date rec'd by registrar) 19 47 Albert R. Swanhom Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7, 1947, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6, 1947 to June 7, 1947 and that I last saw him alive on June 7, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Ruan, M.D. M. D. or other

Address: Henryton, Md. Date signed: 6/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1491

04925

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural 5

(If outside city or town limits, write RURAL and give nearest town)

Street No. Uniontown Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Goldie Elizabeth Fuss

3.(b) Social Security Number None 213-24-8925

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Paul J. Fuss

6.(c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Aug 31, 1912

8. AGE:

Years	Months	Days	If less than one day
34	9	6	hrs. min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Harvey L. Nusbaum

13. Birthplace New Windsor, Md.

MOTHER 14. Maiden name Annie L. Grimm

15. Birthplace New Windsor, Md.

16. Informant Paul J. Fuss

Address Westminster, Md. R.D. 5

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10 - 1947 (month) (day) (year)

Cemetery or crematory Meadow Branch Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard & Sons

Address Westminster, Md.

19. 6 9 1947 (Date rec'd by registrar) H. Bankard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1947, at 5:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1947, to June 7 1947

and that I last saw her alive on June 7 1947

Immediate cause of death	DURATION
Primary uterine & tubal pregnancy	
Shock Hemorrhage	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster, Md. Date signed 6/9/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04926

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 5/3/46
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 1 day, 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
~~Carroll Co.~~
State Maryland County ~~Baltimore City~~
City or town ~~Baltimore~~ Baltimore 23
(If outside city or town limits, write RURAL and give nearest town)
Street No. ~~124 Schroder Street~~ 913 Lemmon St
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME DAVID ROE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	widower

6.(b) Name of husband or wife ? Late Isabelle Roe
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? May 5th 1875

8. AGE: Years	Months	Days	If less than one day
72.	1	24	..... hrs. ..... min.

9. Birthplace Nicholas, West Virginia
(Town, county, and state)
10. Usual occupation Odd jobs
11. Industry or business self
FATHER 12. Name Marion Roe
13. Birthplace Pike, Kentucky
MOTHER 14. Maiden name ? Wakenrow
15. Birthplace Pike, Kentucky
16. Informant Records, Springfield State Hospital
Address Sykesville, Maryland
17. Burial Date thereof 6/12/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill Cem.
Location Patapsco Highway
18. Funeral director John A. Rowsom & Son
Address 900-03 St. Paul St.
19. June 11 1947 A. W. Hyland
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 19 47 at 3:30 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/3/ 19 46 to 6/9 19 47
and that I last saw him alive on 6/9 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Prior to 8/46
Due to	.....
Due to	.....
Other conditions	
Senile Psychosis, simple deterioration ?	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Arnold H. Eichert M.D.
M. D. or other
Address Sykesville, Maryland Date signed 6-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — No. 4927

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 2 Mo's., 8 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1734 N. Calhoun Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN WESLEY SHAW

3.(b) Social Security Number: 217-18-1548

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Dorothy Shaw
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 27, 1905

8. AGE: Years	Months	Days	If less than one day
42	2	13	hrs. min.

8. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Paper Hanger
11. Industry or business:

FATHER
12. Name: William Shaw
13. Birthplace: Maryland

MOTHER
14. Maiden name: Blance Brown
15. Birthplace: Baltimore, Md.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-13-47 (month) (day) (year)
Cemetery or crematory: Arbutus
Location: Balto. County
18. Funeral director: Geo. G. Kelso
Address: 1303 Prentiss. St.

19. 6/9 (Date rec'd by registrar) 19 47 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9, 19 47, at 5.50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 19 46, to June 9, 19 47 and that I last saw him alive on June 9, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 16 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md Date signed: 6/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04928 P

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos, 15 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 mos, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ———
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 436 N. Robinson St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LEO SINNOTT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1904

8. AGE: Years	Months	Days	If less than one day
42	6	24	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Machinist
11. Industry or business: Railroad
FATHER 12. Name: John Sinnott
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Margaret Murphy
MOTHER 15. Birthplace: Ireland
16. Informant: Hospital records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/2/47 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem
Location: 4300 Old Frederick Road
18. Funeral director: John J. Cowan & Son
Address: 901-03 Gallows Street
19. 7/30/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: June 29, 1947 at 6:50 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 14, 1947, to June 29, 1947 and that I last saw him alive on June 29, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	discover 3-17-47
Due to	
Due to	
Other conditions: Schizophrenia, Simple Type	1 yr

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D.
M. D. or other
Address: S.S.Hospital, Sykesville, Md. Date signed: 6-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

049297

93d

Reg. Dist. No. 18C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 4 mo 30 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 4 mo 30 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 715 W. Barre St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Annie (Anna) Snyder

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Snyder

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 20th 1863

8. AGE: Years: 83 Months: 5 Days: 22 If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Practical Nurse

11. Industry or business:

FATHER — 12. Name: Christian H. Schimpf

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Adel Storlock

MOTHER — 15. Birthplace: Germany

16. Informant: Rev. Howard Braunlich

Address: 465 Normandy Ave Balto

17. Burial, cremation, or removal. Which?: Burial Date thereof: 6/16/47 (month) (day) (year)

Cemetery or crematory: Trinity Cem.

Location: Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 6/13 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION 47

20. DATE OF DEATH: June 12th 1947 at 5-55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11th 1945 to June 12 1947 and that I last saw h[illegible] alive on June 12 1947

	DURATION
Immediate cause of death: Chronic Myocarditis	10 yrs
Due to: Arteriosclerosis	10 yrs
Due to:	
Other conditions: Hypertension	"

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. W. Austin M.D. M. D. or other

Address: Sykesville Date signed: 6/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04930

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 15 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Clarksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: FERNANDO STANCIL

3.(b) Social Security Number: 218-05-5218

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 26, 1900

8. AGE: Years	Months	Days	If less than one day
47	1	13	hrs. min.

9. Birthplace: Greenville, N. C.
(Town, county, and state)

10. Usual occupation: Daryman

11. Industry or business

FATHER — 12. Name: Fernando Stancil, Sr.
13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Louisa Teel
15. Birthplace: Greenville, N. C.

18. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-11-47 (month) (day) (year)
Cemetery or crematory: Pitt Co.
Location: Greenville, N.C.
18. Funeral director: Flanagan & Parker
Address: Greenville, N.C.

19. 6/8 19 47 (Date rec'd by registrar) Albert R. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 19 47 at 6.00A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 24, 19 46 to June 8, 19 47 and that I last saw him alive on June 8, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben W. Swan, M. D.
M. D. or other
Address: Henryton, Md. Date signed 6/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04931

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs. 3 mos. 27 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 27 yrs. 3 mos. 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 502 Brunswick Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Ernestine Staples

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Married

6.(b) Name of husband or wife: Fritz Staples
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1884 (day + month unknown)

8. AGE: Years: 63 Months: Days: If less than one day: hrs. min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: None.

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Hospital Records
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 6-5-47 (month) (day) (year)

Cemetery or crematory:
Location: Balto. Md.

18. Funeral director: Williams Rook Inc.
Address: 1217 St Paul St.

19. June 5 1947 C. Henry Lewis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 19 47 at 1:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 19 47, to June 4 19 47
and that I last saw h[illegible] alive on June 4 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 yrs.
Due to:	
Due to:	
Other conditions: Schizophrenia Hebephrenic type (Include pregnancy within 3 months of death)	28 yrs.

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other
Address: Sykesville, Md. Date signed: 6-4-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940 04932

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural - Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural - Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: D. Raymond Stuller

3.(b) Social Security Number: 220-18-1138

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: N. Grace Stuller
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Sept. 12. 1890

8. AGE: Years: 56 | Months: 9 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Montgomery Ward Co.

FATHER
12. Name: Jesse Stuller
13. Birthplace: Maryland

MOTHER
14. Maiden name: Leannah Lindsay
15. Birthplace: Maryland

16. Informant: Mrs. N. Grace Stuller
Address: Westminster, Md

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 6-30-47 (month) (day) (year)
Cemetery ~~or crematory~~: Meadow Branch
Location: near Westminster, Carroll Co. Md.

18. Funeral director: C. M. Walsh
Address: Uniontown, Md.

19. 6/29/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27, 1947, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 27, 1947, to June 29, 1947 and that I last saw him alive on June 29, 1947

Immediate cause of death: Coronary Occlusion — DURATION: 10 hrs.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Hood M.D.
M. D. or other
Address: Westminster, Md. Date signed: 6/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

04933

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 Court

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Bertha Maude Swartzbaugh

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Charles E. Swartzbaugh

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4 - 1875

8. AGE: Years	Months	Days	If less than one day
72	3	14	..... hrs. ..... min.

9. Birthplace Woodsboro, Frd. Co. Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name William Wilson

FATHER 13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden name Not known

MOTHER 15. Birthplace " "

16. Informant Mrs William Lovell

Address New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20, 1947 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

June 20 1947 Grace L. Bankard

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 - 1947, to June 18 1947

and that I last saw h.. alive on June 17 - 1947

Immediate cause of death	DURATION
Diabetes	
Myocarditis (chr)	
Nephritis (chr -	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. C. Jamison M.D. M. D. or other

Address Westminster Md. Date signed 6-18-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

04934 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 8c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. M

MARGIN RESERVED FOR BINDING (I)

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs., 11 mon., 9 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or Institution? 5 yrs., 11 mon., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1218 Eager Street
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME JOHN WAGNER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 25, 1862

8. AGE: Years	Months	Days	If less than one day
84	8	17	hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation storekeeper

11. Industry or business

FATHER 12. Name Francis Maximillion Wagner

13. Birthplace Germany

MOTHER 14. Maiden name Elizabeth Catherine Houst

15. Birthplace Germany

16. Informant Springfield State Hosp. records

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14, 1947 (month) (day) (year)

Cemetery or crematory New Cathedral Cemetery

Location 4300 Old Frederick Rd

18. Funeral director Edward W. Conkling & Son

Address 924 E. Eager St Balto-2-Md

19. 6/13/47 (Date rec'd by registrar) C W Fedrick J.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to June 11 1947 and that I last saw him alive on June 11 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	10 hrs.
Due to Arteriosclerosis	unk.
Due to	
Other conditions Senile psychosis, simple deterioration	unk.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Bertrand May, M.D. M. D. or other

Address Sykesville, Maryland Date signed 6-12-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04935

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Flohrville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Flohrville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural--Sykesville
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LESTER J. WALTZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gertrude B. Waltz
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1883

8. AGE:

Years	Months	Days	If less than one day
63	5	26	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business

FATHER
12. Name: John Preston Waltz
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Jane Reck
15. Birthplace: Maryland

16. Informant: Mrs. Gertrude B. Waltz
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-4-47 (month) (day) (year)
Cemetery or crematory: Deer Park
Location: Smallwood, Carroll Co. Maryland

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. June 3 19 47 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1, 19 47, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Mar 19 46 to June 2 19 47
and that I last saw h[illegible] alive on June 1 19 47

Immediate cause of death	DURATION
Cardio Vascular Renal	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. A. Baumgardner M.D. or other
Address: Westminster, Md. Date signed: 6/4/47

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

04936

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 8 mo's., 24 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Nanticoke (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HAZEL ARETTA WATERS

3.(b) Social Security Number: 219-14-2679

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 22, 1924

8. AGE: Years	Months	Days	If less than one day
23	3	5	..... hrs. ..... min.

9. Birthplace: Nanticoke, Md. (Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business

FATHER
12. Name: Robert Waters
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie E. Barkley
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-30-47 (month) (day) (year)
Cemetery or crematory: Nanticoke
Location: Md.
18. Funeral director: C. S. Messick
Address: Pivalee, Md.

19. 6/27/47 (Date rec'd by registrar) Albert R. Swandale Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27, 1947, at 10.55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3, 1943 to June 27, 1947 and that I last saw her alive on June 27, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Ruben W. Hinman, M. D. M. D. or other
Address: Henryton, Md. Date signed 6/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04937

CERTIFICATE OF DEATH

BC

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yrs., 8 mos., 23 days.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 21 yrs., 8 mos., 23 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -----

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1531 Poplar Grove St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: BERTHA WEBSTER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Joseph Webster

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): January 28, 1865

8. AGE: Years	Months	Days	If less than one day
82	5	1	....hrs. ....min.

9. Birthplace: Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Charles Bauer
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Richenberger
15. Birthplace: Maryland

16. Informant: hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 30. 47 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Balto. Md.

18. Funeral director: Wm. Cook Sons
Address: 211 St Paul Baltimore, Md

19. (Date rec'd by registrar) June 30 1947 C. Henry Zekes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1947 (DST) at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 16, 1941 to June 29 1947 and that I last saw her alive on June 29 1947

Immediate cause of death	DURATION
Chronic Myocarditis	unkn.
Due to: Arteriosclerosis	unkn.
Due to:	
Other conditions: Epilepsy	75 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other

Address: S.S.Hosp. Sykesville, Md. Date signed: 6-29-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04938

134

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 796 W. Saratoga St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPH WILSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec., 22, 1903

8. AGE: Years	Months	Days	If less than one day
43	6	3	hrs. min.

9. Birthplace: Norfolk, Va. (Town, county, and state)

10. Usual occupation: Stevedore

11. Industry or business:

FATHER — 12. Name: Joe Wilson

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Mary ?

MOTHER — 15. Birthplace: Virginia

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27-47 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City

18. Funeral director: Geo. L. Kelson

Address: 1303 Presstman St.

19. 6/25 19 47 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25, 1947, at 2.15A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 23, 1947, to June 25 1947 and that I last saw him alive on June 25, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Brown M. D. M. D. or other

Address: Henryton, Md. Date signed: 6/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04939

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 657 W. Lee Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LUZELL WITHERSPOON

3.(b) Social Security Number: 219-22-4377

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec., 24, 1929

8. AGE: Years	Months	Days	If less than one day
17	6	0	hrs. min.

9. Birthplace: Manning, S. C. (Town, county, and state)

10. Usual occupation: Factory Worker

11. Industry or business:

FATHER — 12. Name: Carlee Witherspoon

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Closanna Felder

MOTHER — 15. Birthplace: South Carolina

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28 47 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem.

Location:

18. Funeral director: Isaac L Brown Son

Address: 108 W Montgomery St

19. 6/24 (Date rec'd by registrar) 19 47 Albert R. Sifferlen Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24, 19 47, at 2.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8, 19 47, to June 24, 19 47 and that I last saw h... in alive on June 24, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Parker Wiseman M.D. M. D. or other

Address: Henryton, Md. Date signed: 6/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04940

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 9 Mo's, 15 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge (If outside city or town limits, write RURAL and give nearest town)
Street No. 415 Pine Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HAZEL LOUISE YOUNG

3.(b) Social Security Number: 216-18-2545

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Nathaniel Young
6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): March 21, 1926

8. AGE: Years	Months	Days	If less than one day
21	2	21	...hrs. ...min.

9. Birthplace: Wolfords, Md. (Town, county, and state)
10. Usual occupation: Canning Factory
11. Industry or business

FATHER
12. Name: Raymond Holliday
13. Birthplace: Williamsburg, Md

MOTHER
14. Maiden name: Elizabeth Coston
15. Birthplace: Wolfords, Md.

16. Informant: Patient
Address: 417 Pine St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 15/47 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Cambridge Md. Bethel
18. Funeral director: Lewis H. Baynum
Address: 201 Washington St. Cambridge Md.

19. 6/11 (Date rec'd by registrar) 19 47 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11, 1947, at 1.30PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug., 27, 1945, to June 11, 1947 and that I last saw her alive on June 11, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md Date signed: 6/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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04941

CERTIFICATE OF DEATH

Reg. Dist. No. 75

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester, Md. Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, Institution, or street address where death occurred: New Melrose

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester, Md. Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Melrose

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clarence Roland Zepp

3.(b) Social Security Number: 220-10-5636

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of ~~husband~~ or wife: Grace Louise Zepp

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): March 7, 1888

8. AGE:

Years	Months	Days	If less than one day
59	3	19	..... hrs. ..... min.

9. Birthplace: Manchester Maryland

(Town, county, and state)

10. Usual occupation: Foreman

11. Industry or business: State Roads Comm.

FATHER

12. Name: (Charles) Henry Zepp

13. Birthplace: Maryland

MOTHER

14. Maiden name: Emma Price

15. Birthplace: Maryland

16. Informant: Mrs. Clarence Zepp

Address: Manchester, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 6-29-47 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Manchester Md

18. Funeral director: Jacob Wilson Sons

Address: Manchester. Md.

19. June 28 1947 Mrs. W. R. S. Denver

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1947, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 12 1947, to June 26 1947 and that I last saw h... alive on June 25 1947

Immediate cause of death	DURATION
Coronary Thrombosis	14 Da.
Due to: Coronary Heart Disease ?	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State): —

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: Joseph E. Buck M.D. M. D. or other

Address: Hampstead Md. Date signed: 6-26-47